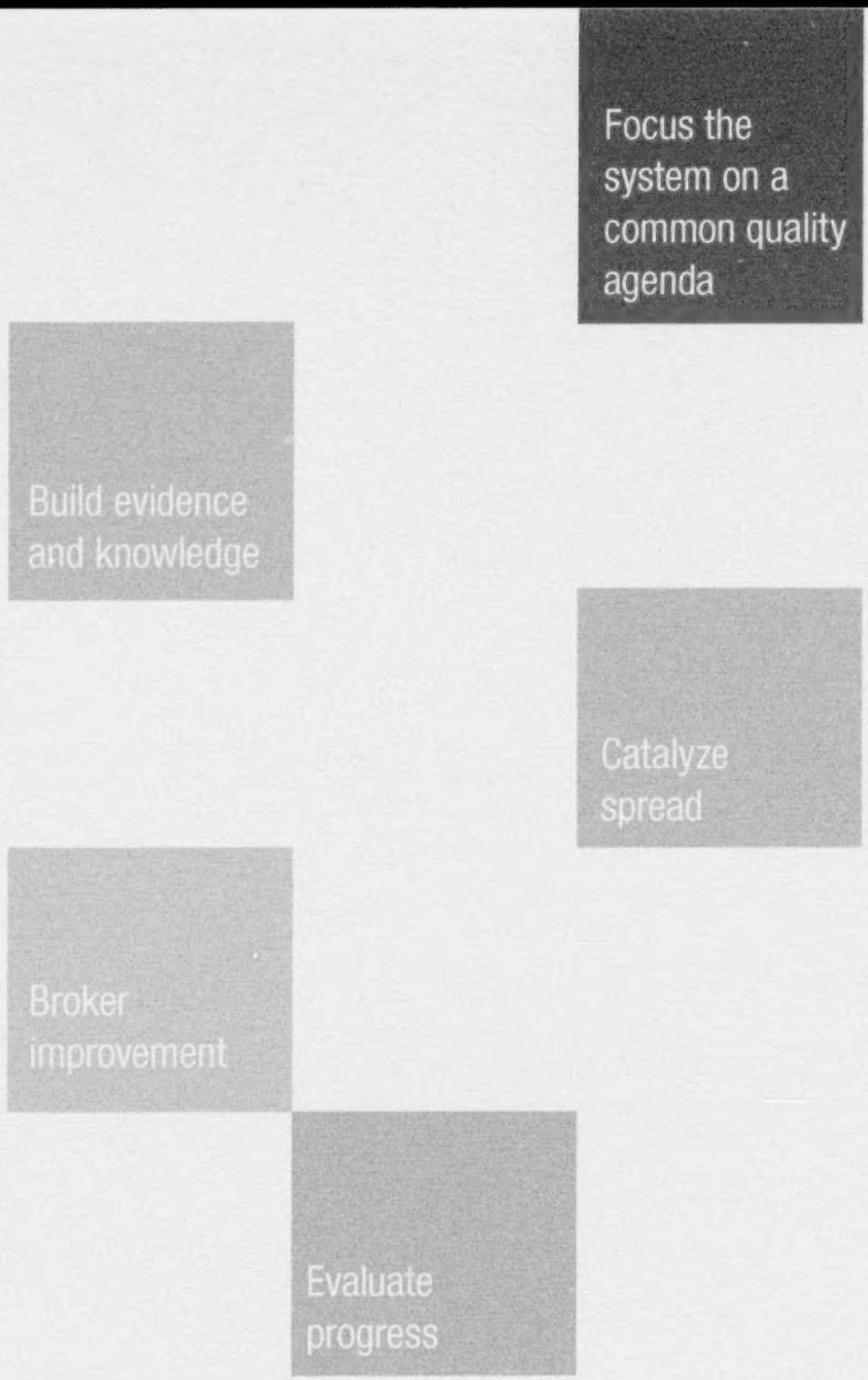
HEALTH QUALITY ONTARIO | 2011–12 ANNUAL REPORT

Ontario

Health Quality Ontario


Focus the system on a common quality agenda
Build evidence and knowledge
Catalyze spread
Broker improvement
Evaluate progress

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Ontario
Health Quality Ontario

The Honourable Deb Matthews
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister:

We are pleased to present you with Health Quality Ontario's Annual Report for 2011–12, containing information on our activities during the first year operating under our broadened mandate, as well as our audited financial statements.

As well as the extensive evidence-based and quality improvement activities described in this report, we have taken care to define our strategic plan and are now optimizing our organizational structure. We believe that having these elements in place enables us, in partnership with health care providers, to provide essential evidence-based quality leadership and support to achieve system aims of better outcomes, better experience and better value for money.

We appreciate your continued support for HQO's work.

Respectfully,

Lyn McLeod,
Board Chair

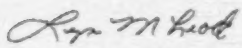
Dr. Ben Chan, MD MPH MPA
Chief Executive Officer

MESSAGE FROM THE CHAIR

Health Quality Ontario (HQO) has a pivotal role to play in ensuring that Ontario's health system is both high-quality and sustainable, by providing the system with evidence and tools to assist with quality improvement, as well as reporting on progress.

Over the course of the past year, we have seized the challenge that was placed before us when the organization was created in April 2011. We have applied leading expertise in evidence, quality improvement and reporting to do so, but we also recognized that integration of HQO's activities would be necessary if HQO was to be a top performer in providing leadership to the health system. Indeed, better integration is critical for the system as a whole if it is to be sustainable. For that reason, we devoted the time and resources necessary to develop our Strategic Plan, in collaboration with leaders in the health system and the Ministry of Health and Long-Term Care, as well as our own staff. HQO is now well-positioned to provide the critical leadership role it has been assigned.

This is the final Annual Report for which I am serving as Chair. It has been a true pleasure to see the passion and commitment inherent at HQO as it has seized its expanded mandate and worked through how best to achieve it. I would like to express my thanks to my board colleagues who have devoted considerable time and effort to ensuring we are on the right track, both with ongoing work and the foundation for our expanded mandate. As well, I want to recognize Dr. Ben Chan and the HQO staff for their dedication to providing the health system with the tools and supports required for sustainable, high-quality performance.



Lyn McLeod,
Board Chair

MESSAGE FROM THE CHIEF EXECUTIVE OFFICER

We take pride in what HQO has been able to achieve over the past year in supporting the health system to improve – the first year operating under our new, broadened mandate – as highlighted in this report. We also look forward to taking our efforts to the next stage, working in partnership with the health system toward achieving our overarching quality aim of better outcomes, better experience and better value for money, featuring our new bestPATH initiative.

I would like to express HQO's sincere appreciation for the strong and skillful leadership and guidance that our Chair, Lyn McLeod, has provided throughout her term, and particularly over the past year. It has been an honour to work with Lyn and she has played an invaluable role in ensuring HQO is well positioned for success.

Dr. Ben Chan, MD MPH MPA
Chief Executive Officer

The work of Health Quality Ontario (HQO) is integral to the government's strategy to transform the health system by improving access to sustainable, high-quality, evidence-based health care.

As part of implementing the *Excellent Care for All Act*, 2010 (ECFAA), the Ministry of Health and Long-Term Care (MOHLTC) decided to consolidate functions from top-quality improvement organizations in the province, in order to drive the development of high-quality, evidence-based health care in Ontario. These organizations became HQO, and this is its first Annual Report under that mantle.

Health Quality Ontario's mandate is derived from ECFAA, which outlines HQO's critical roles as being to monitor and report to the people of Ontario on the quality of their publicly funded health system, to support continuous quality improvement in that system, and to promote healthcare that is supported by the best available scientific evidence.

During 2011–12, we operated on two tracks. We took the formative steps to integrate our functions, to define our path forward, and to start new cross-organizational initiatives, all while continuing to meet the ongoing commitments of our predecessor organizations. In particular:

- We completed our Strategic Plan, aligning our Business Plan and organizational structure;
- We undertook wide-ranging reviews of evidence and made recommendations accordingly;
- We continued to support quality improvement projects in the primary care and long-term care sectors, while supporting the development of publicly available quality improvement plans from all hospitals;
- We continue to enhance our ability to share our partners' best practices through web-based tools as well as events such as our 2011 Leading Healthcare Quality Summit and Innovation Expo;
- We continue to report on the performance of the health system and have worked with the long-term care and home-care sectors to expand the reporting available to the public;
- We are well along in the development of our signature initiative, bestPATH, which will be launched in 2012-13. bestPATH is designed to promote better outcomes and better experience of care for individuals with chronic illness, and better value for money for the health system;
- We continue to put in place the infrastructure we need to provide these services effectively and efficiently, including enterprise project management for our initiatives and an improved web presence; and
- We worked with MOHLTC to put in place appropriate accountability arrangements as we continue to move forward with our expanded mandate.

DEVELOPING OUR STRATEGIC PLAN

HQO was created as a driver to facilitate the health system's move to a high-quality, evidence-based system. It was clear that expectations for us were high, with Ontario's Action Plan for Health Care, the Drummond Report and the 2012 Ontario Budget all emphasizing the importance of the work we currently do, as well as our role moving forward to ensure system sustainability.

Our success depends critically on partnerships with the health system, so it was essential that its voice be reflected in our Strategic Plan. Over the past year, we have undertaken extensive consultations to determine what the health system needs and how HQO can contribute. In addition to discussions with MOHLTC, we were fortunate to have input from 73 external stakeholders and partners from across Ontario, including leaders from:

- Local health integration networks (LHINs)
- The Ontario Hospital Association (OHA), The Council of Academic Hospitals of Ontario (CAHO) and Ontario's hospitals
- The Ontario Medical Association (OMA)
- Long-term care and community care access centres (CCACs)
- Nursing, including the Registered Nurses' Association of Ontario (RNAO)
- Provincial program deliverers
- Primary care

- The Institute for Clinical Evaluative Sciences (ICES)
- eHealth Ontario
- The Canadian Institute for Health Information (CIHI)
- Public health
- Other stakeholders including academic, national and Ontario-based health care improvement organizations

We have also taken stock of HQO's collective expertise and the levers that we can use to help drive system change, engaging our staff throughout the process. As we heard in our stakeholder consultations, we are well positioned for our role because we have all the key elements of a quality strategy in our structure: we build evidence and spread knowledge, we broker improvement and catalyze spread by bringing the system together to collaborate on successful strategies, and we evaluate progress and report on collective results.

The Strategic Roadmap that underpins our Plan is shown below.

Our Values: Transparency, Passion, Innovation, Learning, Integrity, Collaboration

Vision	A healthcare system that is sustainable, improves continually and uses evidence to optimize population health and provide excellent care for all Ontarians		
Mission	A catalyst for quality, an independent source of information on health evidence, a trusted resource for the public		
Transformative Objectives	***Accelerate the use of evidence*** *to deliver demonstrable improvements in the quality of health services*	***Drive a culture of quality, value and accountability*** *throughout the health system in Ontario*	***Forge partnerships and advance integration*** *among the distinct components of the health system*
Overarching Quality Aim	**Better outcomes, better experience, better value for money**		

OUR ROLES

Focus the system on a common quality agenda	Build evidence and knowledge	Broker improvement	Catalyze spread	Evaluate progress
Establish priorities, goals and targets and mobilize system leadership around a common agenda to maximize impact for Ontarians.	Generate or access the evidence and knowledge needed to provide quality care and improve population health, including funding recommendations that set expectations for quality.	Develop the tools and supports needed to accelerate the adoption of evidence-based best practice. Foster the development of quality improvement capacity in the system.	Guide, support and collaborate within the system to spread knowledge about best practices, measurement tools, and implementation strategies. Embed best practices into standards.	Demonstrate accountability by providing timely and relevant health system monitoring, measurement and reporting. Assess progress and report to the public.

During our consultations, we were urged to focus on a core set of priorities and to fully integrate our activities across the organization so that we could maximize our contributions to the system. As the Strategic Plan advanced, we were developing and aligning our Business Plan and organizational structure in tandem, embracing this advice. We are now in the process of implementing our new organizational structure.

EVIDENCE-BASED RECOMMENDATIONS

Health Quality Ontario (HQO) conducts evidence-based analyses to evaluate the effectiveness, cost-effectiveness and safety of health interventions including:

- Medical devices
- Procedures
- Diagnostic, screening, and monitoring tests
- Services

This work is undertaken to support recommendations to the Minister, and to providers, as well as to provide a foundation for our own activities. This effort is overseen by the Ontario Health Technology Advisory Committee (OHTAC) on behalf of the Board, a group of highly knowledgeable scientists and leaders drawn from across the health system.

OHTAC was originally formed to provide advice to the Ministry of Health and Long-Term Care. Early in 2012–13, its transition to being a Board Committee was completed, thereby enabling OHTAC to provide HQO's Board with advice reflecting the real-world perspective of providers and patients, to provide relevant recommendations to the Minister and the health system, and to inform HQO's evidence development work.

Generally, the evidence component of HQO's work can be categorized as follows:

- Preliminary Evidence Reviews — Preliminary Evidence Reviews are conducted when HQO is asked to examine the evidence of effectiveness, safety, and cost-effectiveness for an intervention for which there is insufficient published evidence on the topic to conduct a full evidence-based analysis.
- Evidence-Based Analysis — These are systematic reviews, conducted by HQO, using evidence gleaned from scientific literature, and supplemented by expert panels as necessary, to evaluate the effectiveness, safety and cost-effectiveness of a single technology.

- Mega-analysis — Increasingly, HQO has moved beyond single evidence-based analyses to conduct broader reviews, known as mega-analyses, that examine and compare the effectiveness, cost-effectiveness and safety of multiple interventions for a given disease state or health condition.

- Moving forward in 2012–13, HQO will also be adding new levels of evidence reviews:
  - Rapid Response — To meet pressing information needs facing the Ministry of Health and Long-Term Care, HQO will provide rapid responses (developed within a two week timeframe) in the form of a brief, preliminary overview of the existing evidence.

  - Appropriateness — This work generates evidence-based analyses and recommendations that discourage the overuse, underuse or misuse of health technologies and services in Ontario.

OHTAC reviews all but the Rapid Responses given the time constraints and potential sensitivity of the material in question. In the case of Preliminary Evidence Reviews, OHTAC will have determined that a full review is not possible but might make recommendations based on the available information.

When Evidence-Based Analyses or Mega-Analyses are conducted, OHTAC has the final review of HQO's evidence-development efforts to ensure that the evidence being used is fulsome and current. As recommendations are developed and then reviewed through the public engagement process, OHTAC ensures that outcomes of importance to the public are identified and investigated.

Once OHTAC has completed its work, recommendations with a significant system or financial impact are reviewed with the Board, who must approve them if they are to be forwarded as formal recommendations to the Minister of Health and Long-Term Care.

During 2011–12, OHTAC made recommendations that were approved by the Board in the areas listed below:

- OHTAC made 14 recommendations to the Minister of Health and Long-Term Care dealing with chronic obstructive pulmonary disease management, two of which addressed the need for further research.

- Other recommendations made to the Minister pertained to: seriologic testing for celiac disease, corneal collagen cross-linking corneal thinning disorders; 24-hour ambulatory blood pressure monitoring; pressure ulcer prevention; and endovascular ablation of varicose veins.

- Recommendations made to the health system related to genetic testing for dilated cardiomyopathy; internet-based device-assisted remote monitoring of cardiovascular implantable electronic devices; multiple sclerosis and chronic cerebrospinal venous insufficiency (updated from earlier work); constraint-induced movement therapy for rehabilitation of arm dysfunction after stroke in adults; continuous glucose monitoring for patients with diabetes; diurnal tension curves for assessing the development or progression of glaucoma; and, emerging pharmacogenomics tests.

Summaries of all of these recommendations are contained in the Compendium on Page 20, with full details available at our website: http://www.hqontario.ca/en/mas/ohtac_home.html.

Evidence-Based Funding Supports

Consistent with ECFAA, HQO began to expand its evidence-based role beyond recommendations on health technology and innovations to inform government decision-making around funding policy. Last year, we worked closely with the MOHLTC since it sets the framework for funding. Our efforts were devoted to planning:

- to clarify our respective roles and responsibilities;
- to establish initial areas of focus, including developing an intake process from MOHLTC; and
- to define the scope and nature of recommendations.

We are now well positioned to launch these activities in 2012–13.

Health Quality Ontario plays a notable role in health care quality improvement in Ontario, with its core set of recognized expertise and its track record of delivering successful programs. During 2011–12, we continued to deliver programs in the long-term care and primary care sectors. We supported initiatives with respect to palliative care and behavioural supports. We expanded our reach by working in partnership with MOHLTC and hospitals on their quality improvement plans. Further, we delivered the Leading Healthcare Quality Summit and Innovation Expo in partnership with MOHLTC and the Ontario Hospital Association. We also began work on our flagship program, bestPATH, which will integrate and align efforts across our organization to drive system level change.

RESIDENTS FIRST

Residents First, a five-year provincial strategy for long-term care homes, continued to deliver support across the province for quality improvement initiatives, and towards sustaining and spreading the achieved improvement. HQO worked with long-term care homes on quality improvement projects connected with the prevention of falls and pressure ulcers, continence care, reduced emergency department (ED) utilization, consistency of Personal Support Worker (PSW) assignment and general efficiency improvements (Lean). In 2011–12, 100 long-term care homes received the Residents First Improvement Award, which requires, among other things, that homes demonstrate a 25% improvement in at least one process measure. As well, the Institute for Healthcare Improvement invited HQO to present a case study on the achievements of one of the Residents First participating homes at the Institute's annual quality improvement forum.

Engagement in the initiative was high, with over 186 new homes enrolling in the Residents First initiative in 2011–12, through team and self-directed programs, in addition to the 122 homes already active. Working with these new homes has resulted in the training of 200 Improvement Facilitators and 500 staff to use new knowledge and tools to implement quality improvements in their long-term care homes. Of the new homes in the team-based programs, 47% are already showing results in their quality improvement topics, joining the 63% of the earlier group that have already achieved significant improvement while participating in the initiative.

ADVANCED ACCESS AND EFFICIENCY

Health Quality Ontario has been offering quality improvement initiatives in Advanced Access and Efficiency in primary care, the gateway to the health system, since 2008, as part of its efforts to foster quality improvement capacity in this sector. Its goals are to help primary care practices streamline their operations to reduce wait times for patients, enhance quality and continuity of care, and improve office practices. During 2011–12, we had 200 teams representing over 900 individuals complete the training in our quality improvement initiatives, which extended over several months on a part-time basis. Over 50% of the practices that engaged in the initiative achieved moderate to high levels of improvement on key measures of patient access to primary care.

Starting in February 2011, we expanded our scope from team-based practices (e.g., family health teams and community health centres) to include all primary care practice models (e.g., family health organizations, nurse-practitioner-led clinics, and solo providers). We have been closely monitoring our intake and outcomes to ensure that we are serving the needs of all groups. Going forward, we plan to align this initiative with the bestPATH focus on chronic disease management.

INTEGRATED CLIENT CARE PROJECT — PALLIATIVE CARE (ICCP-PC)

The Integrated Client Care Project — Palliative Care addresses the delivery of palliative care in Ontario, with a focus on understanding current gaps in how palliative care is delivered, together with quality improvement training, to create a more effective and integrated system of care for patients. Health Quality Ontario has worked closely with five pairs of LHINs and CCACs (Central West, Hamilton Niagara, Haldimand Brant, Mississauga Halton, Toronto Central and Waterloo Wellington) as they implemented the ICCP-PC model. A project management office, based in the Ontario Association of Community Care Access Centres (OACCAC), provides central coordination.

Health Quality Ontario has provided training, tools, and coaching in quality improvement science and methodology, including skills development, to sustain and spread the gains from improvement. Highlights from this work were presented by HQO's CEO, Dr. Ben Chan, at the Annual Hospice Palliative Care Ontario Conference 2012. We also led the development of a blueprint of palliative care, which was foundational to the development of outcome-based pathways. While this project is time limited, it is expected to pave the way for future endeavours, with its cross-cutting structure and focus on end-of-life care for the frail elderly.

BEHAVIOURAL SUPPORTS ONTARIO

The Behavioural Supports Ontario (BSO) project addresses the needs of older adults with cognitive impairments due to mental health problems, addictions, dementia or other neurological conditions, who exhibit responsive or challenging behaviours such as aggression, wandering, physical resistance and agitation. This population may live at home, in acute care or in long-term care settings. Using the Framework for Care developed in 2010 by a working group under the auspices of MOHLTC, the BSO project operates under the leadership of the North Simcoe Muskoka LHIN, collaborating with the other LHINs, the Alzheimer Society, the Alzheimer Knowledge Exchange and, for quality improvement and capacity-building training support, with HQO. BSO was implemented across all 14 LHINs; the implementation model was, with the four early-adopter LHINs responsible for spreading their knowledge and experience to the remaining 10 LHINs.

Standardized core competencies and job descriptions have been developed, as well as a capacity-building roadmap distributed to long-term care homes. All LHINs now have action plans, developed with the assistance of HQO coaches and a BSO outreach team. Health Quality Ontario has directly engaged more than 600 participants, representing over 200 organizations from across the health system.

Early indications are that all of these efforts have resulted in reduced hospital lengths of stay. In addition, the newly trained staff are better equipped to support sustained system change and ongoing quality improvement with respect to this patient population.

QUALITY IMPROVEMENT PLANS

Through ECFAA, every hospital must develop a quality improvement plan annually and make it available to the public. Health Quality Ontario worked in partnership with MOHLTC and the OHA to provide guidance to the field in developing their plans. In April 2011, HQO received 152 quality improvement plans (QIPs), one from each hospital in Ontario. For some hospitals, it was the first QIP they had ever created. For HQO, it was the first opportunity to examine hospital QIPs from across the province, and to use the analysis to provide supports to hospitals to help them both improve their plans and their ability to implement them.

In 2011–12, we published our analysis of the hospital QIPs: *2011 Quality Improvement Plan: An Analysis for Learning*. In this report, we recognized that all hospitals complied with the legislative requirement and noted the effort required to do so. We identified some of the challenges hospitals experienced in developing their QIPs and explored the root causes, and we highlighted some examples of plans that stood out for having a clear vision and a strategy for improvement. The report also provided information to help hospitals in the development of their 2012 QIPs.

Using what was learned and feedback from the 2011 process, HQO contributed to the redesign of QIP guidance materials to assist hospitals in meeting the legislative requirements in 2012 and to enable HQO to make province-wide comparisons on a minimum set of quality indicators.

bestPATH

bestPATH (Person-centred, Appropriate, Timely, Healthcare) is our new flagship initiative. It will integrate all of HQO's strategic levers to help drive system-wide change to achieve the best care, best health and best value for Ontarians. bestPATH will focus the system on optimizing the care it delivers to Ontarians. Initial target populations will be Ontarians with complex chronic illness, such as one or more of diabetes, congestive heart failure, coronary artery disease, stroke and chronic obstructive pulmonary disease. These individuals have complex care needs, involving primary care, home care, hospitals and specialists.

Managing these conditions requires smooth transitions between these types of care, and that the treatments have scientifically proven benefits. Otherwise, these Ontarians' conditions can become worse, requiring hospitalizations that might have been avoided. With the right care, their quality of life can be improved, reducing the burden on families and the health system.

The interventions are designed to be broadly applicable with appropriate modifications to benefit the broader public, and we will work diligently to support widespread adoption for maximum impact.

The initial foci of clinical change ideas are grouped into the following categories:

- Transitions
- Independence and safety
- Chronic disease management

The content, timing and execution of activities of this complex initiative are being developed in collaboration with MOHLTC and our partners in the health system, including LHINs. bestPATH will launch in 2012–13.

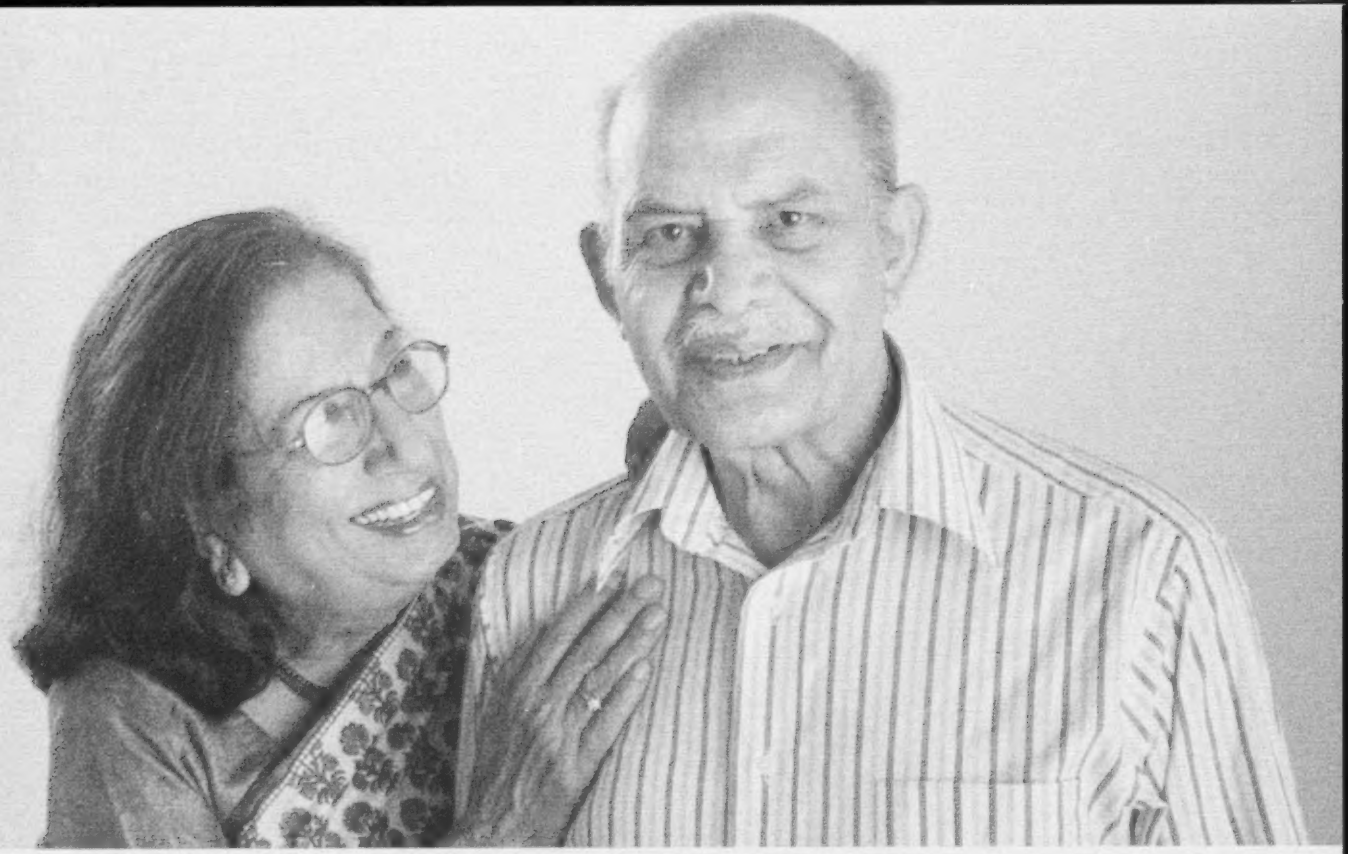
LEADING HEALTHCARE QUALITY SUMMIT AND INNOVATIONS EXPO

On November 9, 2011, HQO, along with MOHLTC and the OHA, co-hosted the Leading Healthcare Quality Summit and Innovations Expo at the Metro Toronto Convention Centre.

This was the first time HQO had a role in delivering the event, and the organization was responsible for creating the content for and delivery of three learning sessions. Topics included building a quality improvement champions network and the hospital quality improvement plans mandated under ECFAA. Dr. Ben Chan, HQO's CEO, moderated a panel discussion about avoidable hospitalizations, starting a dialogue with health system leaders that informed the development of the bestPATH initiative.

Invited panelists and the more than 900 participants representing all sectors of the healthcare system attended this interactive, idea-sharing forum. Close to 50 exhibitors showcased their innovative ideas and quality improvement successes.

The Minister of Health and Long-Term Care spoke at the event, toured the exhibit floor and presented a People's Choice Award for the best exhibit.



A key component of HQO's mandate is public reporting. During 2011–12, we released our yearly report on the state of Ontario's health system, ***Quality Monitor*** (or "Q Monitor," as it is commonly referred to), and also launched updated and improved websites reporting on long-term care and home care quality in the province.

QUALITY MONITOR

Q Monitor was released on June 2, 2011, by the Chair and CEO. The report highlighted that there were still too many patients occupying alternative levels of care (ALC) beds in the province's hospitals and that wait times for long-term care remained very high. Health Quality Ontario called upon the Ontario Government to tackle the root causes of the ALC situation.

Broadly speaking, the report highlighted three areas that needed to be addressed to improve the overall quality of the healthcare system: access to health care, chronic disease management and addressing population health, especially issues such as smoking, obesity, exercise and diet.

On the positive side, the report also drew attention to many significant achievements, including improvements in primary care access and patient outcomes for coronary artery disease, reductions in wait times for many surgeries and CT scans, and declining smoking rates. Emergency wait times were also dropping but remained far from ideal.

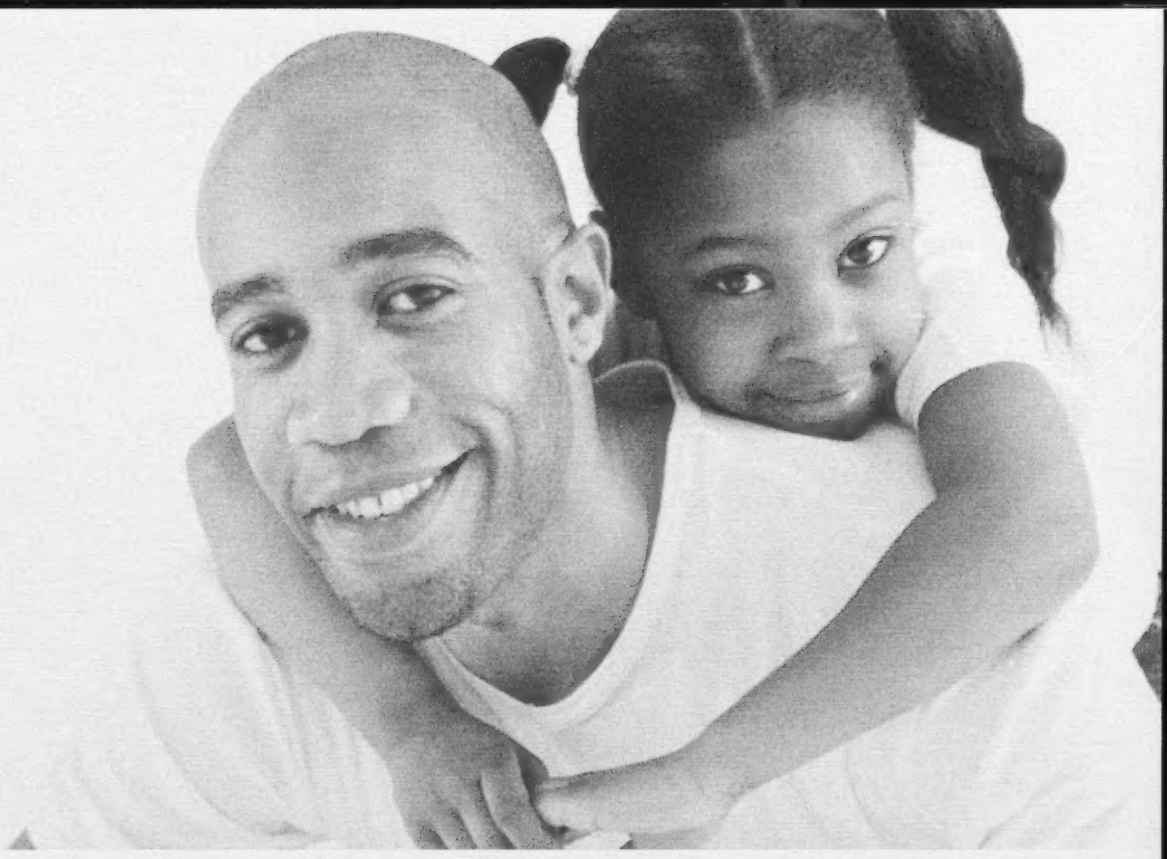
To encourage the spread of innovative ideas, the report also included several examples of quality improvement strategies that are achieving positive results for the health system.

LONG-TERM CARE REPORTING

On March 28, 2012, HQO launched its updated and revamped public reporting websites on long-term care homes and home care quality. By making performance transparent, these organizations are encouraged to improve. Nearly 300 homes voluntarily posted their results for quality indicators related to incontinence, falls, pressure ulcers, and restraints, a 300% increase over the number of homes reporting in 2011. By the end of 2012, it is expected that data for all long-term care homes will be posted. The information is provided at the provincial level and the public can also search for homes by postal code or LHIN.

HOME CARE REPORTING

The home care website includes results for 11 home care quality indicators relating to topics such as wait times, incontinence, cognitive function and pressure ulcers. The information is provided at both the provincial and CCAC level, and the site also includes information about client experiences. It has subsequently been recognized by the Health Council of Canada in its *Progress Report 2012: Health Care Renewal in Canada* as the first public reporting source for quality of home care services in Canada.



Investing in organizational excellence is essential if HQO wants to be an exemplar for health quality in Ontario. Over this year, we have been putting in place the infrastructure necessary to support effective business practices.

At the start of the year, we made major efforts to ensure that we were adequately staffed to pursue the expanded mandate, including hiring people previously engaged by our predecessor organizations and receiving those transferring from MOHLTC who worked on evidence development. We also worked with MOHLTC to finalize our accountability agreement for 2011–12, and developed our first Business Plan. We engaged our staff extensively, as well as stakeholders, to forge our Strategic Plan. With the plan complete, we are now moving to align our organizational structure. We have also helped our board update its governance structures so that they correspond to our revised mandate.

We are well along in implementing integrated project management to help us ensure that deliverables stay on track, and we have expanded our financial reporting capacity with a more comprehensive chart of accounts. We also arranged to transfer the information assets of our predecessor organizations. Further, we took steps to enhance our information technology arrangements to ensure that we had sufficient capacity and equipment to support the new scale of the organization.

Health Quality Ontario requires a robust ability to communicate and interact with health providers and the public. We have therefore established a web consolidation project that is working to implement a three-year web strategy. Initially, the activities were focused on transitioning the web materials of our predecessor organizations, but we are now integrating and expanding to include addition relevant information related to acute care and patient safety. We also plan to improve our back-end functionality, to support our health system reporting requirements.

In all our activities, we keep sustainability and cost effectiveness in mind. We are planning for much greater reliance on webcasts and teleconferences to reduce travel costs, and have designed this into our upgraded IT systems. After consolidating our IT support arrangements, we retendered for greater cost effectiveness. And, over the course of the year, we have reduced our office locations from four to two.

PERFORMANCE MEASURES

Since 2011–12 was the first year that HQO operated as a consolidated entity, we needed to expend considerable effort to define our programs and projects and then put resourcing in place. As such, we have generally been dealing with milestones rather than performance measures, and while we met many milestones, we did have some issues to resolve, primarily due to the broad range of activities that were being initiated and the need to align plans and resources.

Over the course of 2011–12, we have defined performance measures for quality improvement projects that will continue to be used, and we intend to expand our performance measure coverage to the full range of our activity in 2012–13. Our new Strategic Plan provides the performance measurement framework.

We have also defined and begun to execute processes to track our performance that make provision for corrective action, if required. Clear accountabilities for performance have been assigned to members of our senior management team as appropriate. Monthly and quarterly reports on the progress of our initiatives, as well as quarterly performance reports, are reviewed by the team as a whole, so that they can then address any performance issues that arise. As well, our board receives and reviews our quarterly initiative and performance reports, in addition to quarterly financial reports.

FINANCIAL PERFORMANCE

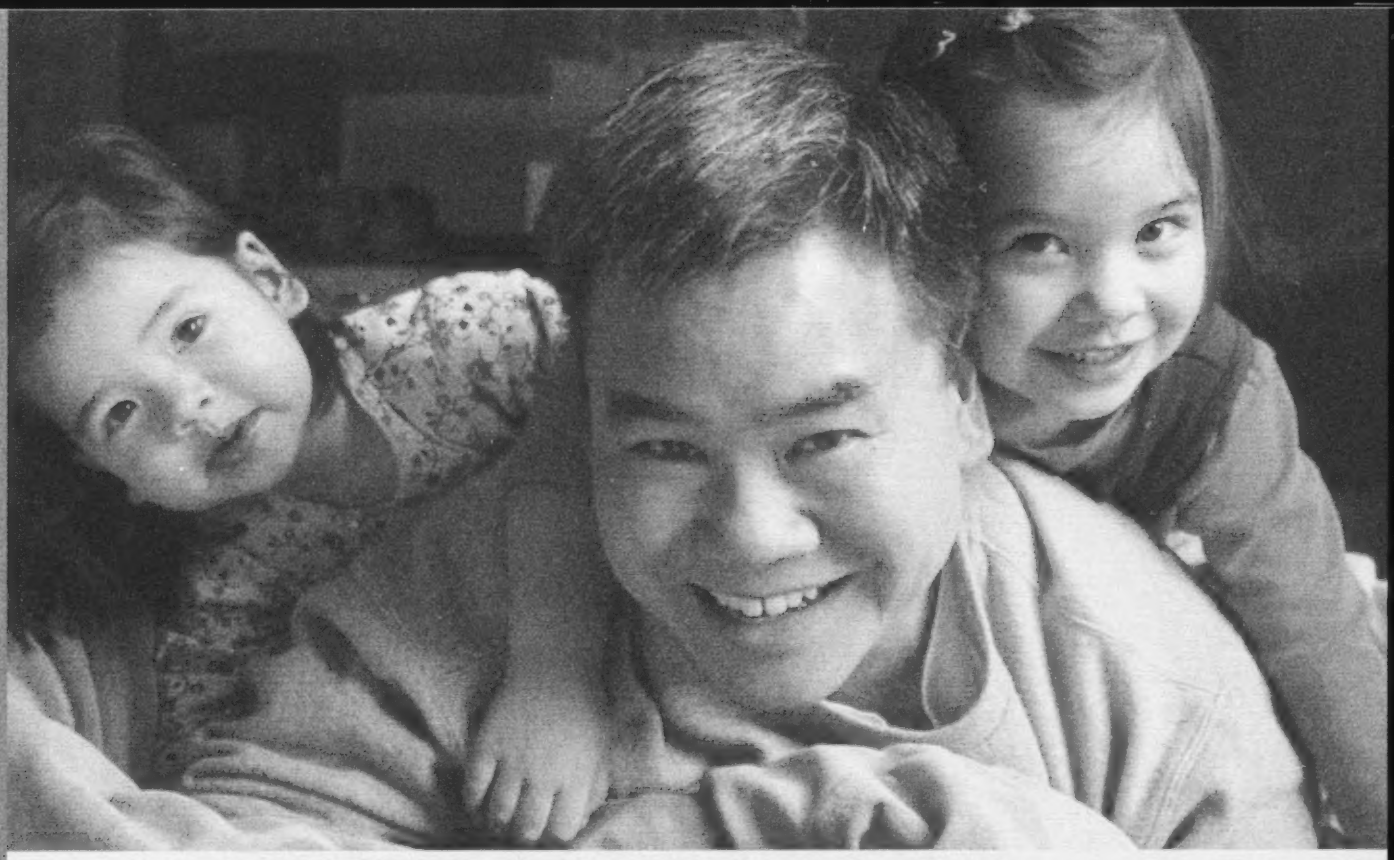
Commensurate with our expanded mandate and consolidation of functions, HQO's funding increased from $7.4 million in 2010–11 to $30.5 million in 2011–12. The largest increases arose from the expanded quality improvement initiatives assigned to HQO, and from the transfer of the Ontario Health Technology Evalulation Fund, which was used to fund field evaluations and health economic analyses performed by our partners. In addition, consistent with its focus on evidence, HQO expanded its investment in research and data-gathering activities to support its evidence-based work and its public reporting on the state of Ontario's health system.

To enable the consolidation of functions, transition funding was provided to HQO. The work of a transition team, initially formed in 2010–11, continued into 2011–12. Among other activities, the team supported: the negotiation of the Memorandum of Understanding and Accountability Agreement with MOHLTC, the preparation of the Business Plan, the drafting of the by-law and terms of reference for OHTAC, the development of policies and procedures, the hiring of staff, the formation of project management and governance offices, a variety of procurements, and the merger of four budgeting and reporting systems.

To address the larger staff complement, HQO invested in its infrastructure. Over the course of 2011–12, HQO invested in renovation and leasehold improvements, taking occupancy of new space so that we could consolidate the four locations of the predecessor organizations into two. We also acquired a new phone system and implemented a higher capacity, more robust information technology infrastructure (including network, switches, servers and offsite data storage) to accommodate the larger number of staff, all working from a variety of locations due to the nature of the organization's activities.

Health Quality Ontario completed the year with a $3.3-million surplus. As a transformative entity, defining its strategic plan and culture while concurrently defining and executing its initiatives, HQO's foundational-year budget reflected a more extensive agenda than it was able to achieve. Moving forward — with the strategic plan, organizational structure, a merged culture and appropriate infrastructure in place — HQO begins 2012–13 well positioned to execute its broad mandate successfully.

Detailed financial information can be found in the Audited Financial Statements, beginning on page 26.



Health Quality Ontario operates under the oversight of a board that consists of between nine and 12 members appointed by the Lieutenant Governor in Council, including the designated chair and vice chair. The legislation also specifies a skill mix to be considered. All members work for the board on a part-time basis.

Board membership for 2011–12 is shown below — with their terms:

Board Member	Term
Lyn McLeod (Chair)	August 18, 2005—August 17, 2012
André Hurtubise	February 18, 2009—February 17, 2012
Bob Gardner	January 27, 2010—January 26, 2013
Gilbert Sharpe	March 3, 2010—March 2, 2013
Richard Alvarez	January 4, 2011—January 3, 2014
Andy Molino	April 16, 2008—August 15, 2014
Marie Fortier (Vice Chair)	May 4, 2011—May 3, 2014
Tazim Virani	May 17, 2011—May 16, 2014
Faith Donald	January 27, 2010—August 17, 2014
Jeremy Grimshaw	August 18, 2011—August 17, 2014

This year was our foundational year. As well as delivering a large number of evidence and quality improvement initiatives, as have been itemized in this report, we considered it critically important to spend time and effort defining our Strategic Plan and moving to optimize our organizational structure. With these endeavours largely complete, working with health system partners we are now able to move forward effectively with our critical role of providing high-quality evidence-based quality leadership and support towards the goal of better outcomes, better experience and better value for money.

To meet requirements under its Accountability Agreement with MOHLTC, HQO is providing a summary of all of the evidence-based recommendations made to the Minister of Health and Long-Term Care or to the health system over the course of 2011–12. Complete details are available on the HQO website at: http://www.hqontario.ca/en/mas/ohtac_home.html.

RECOMMENDATIONS TO THE MINISTER ON CHRONIC OBSTRUCTIVE PULMONARY DISEASE

During 2011–12, OHTAC completed its recommendations on treatment strategies for Chronic Obstructive Pulmonary Disease (COPD): HQO conducted nine evidence-based analyses of treatment strategies across the COPD spectrum.

COPD is the fourth leading cause of death in Canada and a leading cause of morbidity. A recent Ontario study found that one in four people will likely experience COPD in their lifetime. In addition, it is a leading cause of health care utilization, including hospitalizations and emergency room visits. The substantial impact of COPD can translate into a large economic burden for both individuals and society.

The review was undertaken at the request of MOHLTC. OHTAC made 14 recommendations to guide the investment of health care resources within a provincial strategy for COPD and these were approved by the HQO Board to be conveyed to the Minister. These recommendations are summarized as follows:

- To address gaps in public knowledge about this disease
- To maximize the use of pneumococcal and influenza vaccines in COPD patients
- To adopt evidence-based strategies to encourage smoking cessation in COPD patients (including intensive counselling of at least 90 minutes as the most effective, with training programs to health professionals providing it, and buproprion or nicotine replacement therapies)
- To provide ongoing access to existing community-based multidisciplinary care for the management of moderate to severe COPD in stable patients
- To provide ongoing access to existing pulmonary rehabilitation for the management of moderate to severe COPD in stable patients
- To continue to make available long-term oxygen therapy to COPD patients with severe resting hypoxemia (low oxygen in the blood ≤ 55 mmHg)
- Not to use non-invasive positive pressure ventilation (NPPV) for chronic respiratory failure in stable COPD patients due to its lack of clinical effectiveness
- To use pulmonary rehabilitation in patients following an acute exacerbation, a sudden worsening of symptoms (within 1 month of hospital discharge)
- To use NPPV as an adjunct to usual medical care as a first-line treatment for patients with acute respiratory failure due to acute exacerbations of COPD who do not require immediate access to invasive mechanical ventilation (IMV). NPPV should be made widely available, with appropriate support systems and human resources for this indication
- To use NPPV to wean COPD patients who have failed spontaneous breathing tests following IMV
- To expect health providers to seek patient preferences regarding mechanical ventilation prior to acute respiratory decompensation, and to use these as a guide for the provision of this service.

In putting forward these recommendations, HQO also provided the Ministry of Health and Long-Term Care with high level implementation considerations.

The remaining COPD recommendations addressed areas for further research. Specifically, since the evidence was of low quality but the potential for benefits was high, OHTAC called for field evaluations on pulmonary rehabilitation maintenance programs and tele-monitoring. OHTAC also provided a list of treatment strategies where there was insufficient evidence for it to make recommendations.

OTHER RECOMMENDATIONS TO THE MINISTER

Four other recommendations were made to the Minister by OHTAC. Two of these, Pressure Ulcer Prevention and Endovascular Ablation of Varicose Veins, predated the transition to HQO. All are summarized below:

- **Serologic Testing for Celiac Disease** – Celiac disease is an autoimmune disease that develops in genetically predisposed individuals. The immunological response is triggered by ingestion of gluten, a protein that is present in wheat, rye and barley. The treatment for celiac disease consists of strict lifelong adherence to a gluten-free diet. Serologic tests have been developed to detect celiac disease and are not insured services under OHIP, although they are covered by other provinces. The cost is between $60 and $125 per test. Confirmation is done through small bowel biopsies.

OHTAC had earlier made recommendations concerning those with the usual symptoms: gastrointestinal indications, unexplained anemia unresponsive to iron supplementation and dermatitis herpetiformis (an extremely itchy rash made up of bumps and blisters). However, there are other individuals with celiac disease who are asymptomatic, including some with Type 1 diabetes, some with autoimmune thyroid disease and some with a first degree relative. OHTAC considered the effectiveness of the various serologic tests.

OHTAC found that the Anti-tissue Transglutaminase Antibody test using Immunoglobin A measurement was most effective of the tests evaluated. Of the asymptomatic patients, only those pediatric patients with idiopathic (unexplained) short stature were recommended by OHTAC for routine testing. It was also noted that undertaking the serologic testing and then confirming with the biopsy was more cost effective than doing the biopsy alone but ran the risk of more false negatives. The recommendation, if physicians were required to establish that the appropriate criteria for asymptomatic pediatric patients with idiopathic short stature were evidenced, was estimated to cost an additional $552,000.

- **Corneal Collagen Cross-Linking Corneal Thinning Disorders** – Corneal thinning comprises a range of disorders involving either primary diseases such as keratoconus or secondary conditions such as those occurring after LASIK refractive surgery. Keratoconus is the most common reason. It is a rare disease but has an early onset with a median age of 25 years. Corneal thinning leads to an irregular corneal shape, which in turn results in significant loss of visual acuity, making it difficult to perform simple daily tasks such as driving, watching television or reading. Patients are referred for corneal transplant as a last option when they can no longer tolerate contact lenses or when lenses no longer provide adequate vision.

The corneal collagen cross-linking treatment (CXL) is an irreversible procedure using riboflavin and ultraviolet-A to prevent further progression of corneal thinning by stiffening the underlying collagen support. CXL is currently the only procedure to treat the underlying disease condition and is minimally invasive, safe and effective. It does not limit subsequent surgical approaches or interfere with corneal transplant but may defer the need for the latter.

After reviewing the evidence and the results from consultations with experts, OHTAC recommended that the CXL treatment be made available to those with corneal thinning disorders, such as kertoconus, that are progressive in nature. OHTAC also noted that since the procedure did not always improve visual acuity, additional procedures, such as intrastromal corneal ring segments, might need to be considered for visual rehabilitation and to avoid a corneal transplant. OHTAC noted that the treatment is not currently an insured service under OHIP and that consideration would need to be given to appropriate physicians' fees, professional standards, regulations and appropriate settings for CXL to be performed. The estimated annual cost was $2.1 million.

• Pressure Ulcer Prevention – In December of 2011, recommendations were conveyed to the Minister on pressure ulcer prevention that stemmed from work completed by OHTAC in 2009. A pressure ulcer, or bed sore, is an area of localized injury to the skin and/or underlying tissue caused by pressure and rubbing, most often over a bony prominence. Although treatable if found early, they can become life-threatening, and in rare cases, can lead to fatal infections. People at risk for developing pressure ulcers are the elderly and critically ill, as well as persons with neurological impairments and those with conditions associated with immobility. A 2004 survey of Canadian health care settings estimated that the prevalence of pressure ulcers in Ontario ranged between 13 and 53%, with non-acute health care settings exhibiting the highest rate. As well, it was estimated that pressure ulcers cost the Canadian health care system approximately $2.1 billion annually.

Current practices for the prevention of pressure ulcers include pressure redistribution devices such as alternative foam mattresses, nutritional supplementation, patient repositioning regimens, and incontinence management.

After reviewing the evidence for the various methods to prevent pressure ulcers, OHTAC recommended:

- for **Acute Care,** that a high-quality foam mattress be provided to all persons;
- for **Operating Rooms,** that a high-quality support surface (foam or gel) should be used during surgical procedures greater than 90 minutes in duration, with the strongest evidence for gel pads;
- for **Long-Term Care,** that a high-quality foam mattress should be provided to all residents in long-term care facilities; and
- for **Community Care,** that the Community Care Access Centres should use the Pressure Ulcer Risk Score to assess clients' risk for developing a pressure ulcer. Where risk is identified, a high density foam mattress should be used.

The costs and benefits were estimated as follows:

- for **Acute Care,** the one-time implementation costs would be $2.1 million in emergency departments (ED), and this would prevent 1,005 ED-acquired pressure ulcer cases per year for an annual savings of approximately $7.2 million in hospital costs;
- for **Operating Rooms,** the one-time implementation costs would be $1.9 million to provide gel-filled overlays on operating tables which would prevent 760 cases, saving about $7.0 million annually in health care costs;
- for **Long-Term Care,** the one-time cost of $8.8 million to upgrade to foam mattresses would prevent 1,597 facility-acquired cases per year and save about $1.3 million annually in health care costs; and
- for **Community Care,** the annual implementation cost would be $7.2 million for long-stay clients of Community Care Access Centres who are at high risk of developing pressure ulcers. This would prevent 974 cases per year and save approximately $0.5 million per year in health care costs.

• Endovascular Radiofrequency Ablation of Varicose Veins – In December of 2011, recommendations were relayed to the Ministry on the effectiveness and safety of endovascular radiofrequency ablation (RFA) for the treatment of primary varicose veins based on work completed by OHTAC in January 2011. Varicose veins of the lower limb occur commonly in adults and there is a strong inheritance pattern. The estimated prevalence is 5-15% for men and 3-29% for women. Varicose veins are tortuous, twisted or elongated veins caused by poorly functioning valves and decreased elasticity in the vein walls, resulting in venous reflux (reversed blood flow in the vein). The symptoms of venous reflux can include: aching leg pain, leg swelling, throbbing, night cramps, restless legs, leg fatigue and heaviness or itching or burning. Pronounced venous reflux left untreated can lead to chronic venous insufficiency (CVI) where the veins cannot pump enough oxygen-poor blood back to the heart. The clinical signs of CVI can include a spectrum of conditions: edema, hyperpigmentation, eczema, lipodermatosclerosis and ulcers. CVI is associated with a reduced quality of life, particularly in relation to pain, physical function and mobility. In severe cases, the quality of life has been rated to be as poor as or worse than other chronic diseases such as back pain and arthritis.

Surgery is the main treatment for varicose veins and involves surgically removing the affected veins (vein stripping). The main drawbacks of surgical stripping are it that requires operating room time and general anaesthesia, and is associated with prolonged recovery times and a high rate of recurrence.

Endovascular techniques introduce a potentially important alternative to surgery. They use thermal energy to destroy the vein wall. The advantages are that it is minimally invasive, can be performed in an outpatient setting and does not require general anaesthesia. Two main techniques are used:

- **Laser ablation (ELT)** – uses a laser fibre to deliver heat energy to the damaged vein segments, and
- **Radiofrequency ablation (RFA)** – uses a radiofrequency catheter to deliver heat energy to damaged vein segments.

While surgical stripping is an insured service in Ontario, neither endovascular ablation techniques were insured and were being performed primarily in private clinics.

OHTAC's recommendations were:

- Endovascular treatment of varicose veins is a less invasive, safe and effective alternative to vein stripping that should be made available to people with symptomatic varicose veins and saphenous venous reflux demonstrated on a full duplex ultrasound investigation, and when feasible, following a failed trial of conservative management.
- While there is an absolute medical necessity for a surgical approach by any method (including ELT or RFT) for treatment of varicose veins associated with venous ulcer, thrombophlebitis or bleeding, the decision to recommend a similar treatment approach based on other moderate to severe symptoms attributed to CVI (such as leg pain, edema, pigmentation, eczema or lipodermatosclerosis) should be made on an individual basis and guided by established definitions of disease severity such as the Venous Clinical Severity Score.
- Mechanisms to ensure quality assurance for both the physicians performing endovascular treatments and the facility where the treatments are being performed should be considered part of any implementation plan.

It is projected that the province's average incremental cost for funding ablation treatments would be $4 million per year ($3 million for ELT and $1 million for RFA) beyond the $1.8 million per year spent on surgical stripping, assuming that capital costs were amortized over five years.

RECOMMENDATIONS TO THE HEALTH SYSTEM

The remaining recommendations OHTAC made for the health system during 2011–12 are summarized below.

- **Genetic Testing for Dilated Cardiomyopathy** – Dilated cardiomyopathy (DCM) is a condition in which the heart becomes weakened and enlarged, impacting its ability to pump blood effectively. It is a common cause of heart failure for children and adults. In children it is the most common type of heart muscle disease. At least 1 in 2,500 individuals currently live with DCM; however, the condition is considered largely underdiagnosed since subjects are often asymptomatic until serious symptoms arise.

At the request of OHTAC, HQO conducted a preliminary evidence review of the diagnostic accuracy and clinical utility of genetic testing for DCM. After considering the lack of evidence regarding the diagnostic accuracy of genetic testing and its impact on clinical outcomes and disease management, OHTAC did not recommend access to genetic testing for individuals diagnosed with the disease or for their immediate or extended family members.

• **Internet-Based Device-Assisted Remote Monitoring of Cardiovascular Implantable Electronic Devices** – Cardiovascular implantable devices consist of pacemakers and cardioverter defibrillators used to treat heart failure and irregular heart activity. Currently, patients with these devices regularly visit outpatient clinics so that physicians can ensure that their device is performing correctly and monitor for any cardiac arrhythmias (abnormal heartbeats). However, relying on these scheduled visits may mean that asymptomatic arrhythmic events may be discovered weeks or months after they occurred, resulting in delayed adjustments to the implanted device or to the patients' medical management.

Remote (or home) monitoring systems (RMSs) were developed to provide physicians with data from the implantable devices with little or no delay. They also have the potential to reduce follow-up time in clinics, reduce physician workload, and lower patient transportation costs – especially for locations that lack outpatient clinics. However, they do not completely eliminate visits to clinics since patients still need appointments to have their devices adjusted.

On the basis of an evidence-based review and a clinical engagement process, OHTAC concluded that RMSs should be increasingly used in patients who have difficulty accessing outpatient clinics for geographic or other reasons. OHTAC also recognized that there was diversity of implementation, broader organizational issues and lack of information on these systems. OHTAC therefore recommended the establishment of an expert panel with a mandate for forward planning on the broader organizational issues that may influence the direction and potential outcomes of RMSs implemented in clinical practices seeking efficiencies for long-term surveillance of a growing patient burden.

• **Update on Multiple Sclerosis and Chronic Cerebrospinal Venous Insufficiency** – Multiple Sclerosis (MS) is a chronic progressive neurologic disease believed to have an autoimmune origin. A more recent theory proposes that an abnormality in the drainage of blood from the brain and spinal cord, chronic cerebrospinal venous insufficiency (CCSVI), may be associated with MS.

In May 2010, the Medical Advisory Secretariat (MAS – now part of HQO) published a preliminary evidence review on Multiple Sclerosis and Chronic Cerebrospinal Venous Insufficiency. The review concluded that although the initial reports on intravascular interventions to remove blockages in cranial veins in MS were encouraging, unanswered questions nevertheless remained: the association between the proposed condition of CCSVI and MS; the criteria to diagnose CCSVI; and the neuroimaging technologies used to investigate CCSVI.

In December 2011, OHTAC published the results of updating its preliminary evidence review up to July 2011. OHTAC was unable to make any recommendations at that time due to the paucity of available evidence and regarded the treatment as experimental. As such, patients with MS that want these investigations were encouraged to participate in clinical trials. OHTAC indicated it will continue to monitor new evidence closely.

• **Constraint-Induced Movement Therapy for Rehabilitation of Arm Dysfunction After Stroke in Adults** – About 1% of the population lives with the effects of stroke, and up to 85% of those experiencing a complete stroke may have residual impairments of arm functioning that interfere with their ability to live independently. Constraint-Induced Movement Therapy (CIMT) is a behavioural approach to stroke rehabilitation for people with arm dysfunction. The major components of CIMT include:

- intense repetitive task-oriented training of the impaired limb for several hours a day for 10-15 days;
- immobilization of the unimpaired arm for up to 90% of waking hours; and,
- shaping by progressively increasing the difficulty of the training tasks as performance improves and providing immediate encouraging feedback when small gains are achieved.

After reviewing the evidence assembled by HQO, obtaining comments from two leading experts in stroke rehabilitation and a public engagement process, OHTAC found that CIMT showed short-term effectiveness on arm function. OHTAC recommended that CIMT be considered in the stroke rehabilitation regime beginning no earlier than one month after stroke onset. OHTAC noted that these

findings needed to be contextualized in terms of the management of stroke rehabilitation in Ontario. OHTAC also supported the 2010 ICES Stroke Evaluation Report recommendations regarding outpatient stroke rehabilitation care access and tracking.

• **Continuous Glucose Monitoring for Patients with Diabetes** – About 9% of the population is diabetic and many require insulin therapy. Conventional self-monitoring of blood glucose is performed by taking a finger capillary blood sample and measuring it using a small handheld device. While accurate at the time of measurement, it can miss marked fluctuations, hindering optimal treatment. Continuous glucose monitors measure glucose levels in the fluid surrounding skin cells, continuously over a stipulated time period, thereby identifying fluctuations that would otherwise be missed.

A literature search was conducted by HQO to determine the effectiveness and cost-effectiveness of continuous glucose monitoring combined with self-monitoring of blood glucose compared with self-monitoring of blood glucose alone in the management of insulin-dependent diabetes. Clinical experts were then consulted.

OHTAC did not recommend continuous glucose monitoring combined with self- monitoring of blood glucose for the management of insulin-dependent diabetes.

• **Diurnal Tension Curves for Assessing the Development or Progression of Glaucoma** – Elevated interocular pressure (IOP) is a risk factor for glaucoma. However, a single reading in the physician's office may not reveal the range of IOPs that a patient experiences; indeed, population-based studies have indicated that one third to one half of patients who experienced visual field loss from glaucoma had normal IOP readings at the initial examination. Multiple intraocular pressure (IOP) measurements over the course of a day can be used to generate a diurnal tension curve and could have clinical importance in terms of diagnosis and management of patients with IOP-related conditions.

HQO conducted an evidence-based analysis to determine whether the use of a diurnal tension curve was more effective than single IOP measurements for assessing IOP as a risk factor for the development or progression of glaucoma, and whether it led to more effective disease management for those suspected of having glaucoma or those with progressive glaucoma despite normal single IOP office measurements.

Based on the review of evidence and consultation with a clinical expert in Ophthalmology, OHTAC did not recommend the adoption of diurnal tension curves in the management of glaucoma due to insufficient supporting evidence.

• **Emerging Pharmacogenomic Tests** – Pharmacogenomic tests have the potential to determine the individual patient's responsiveness to various treatments, including chemotherapy, based on their genes. Some of these treatments come with severe side effects. The Medical Advisory Secretariat, now part of HQO, was asked by Cancer Care Ontario in February 2010 to analyze three high profile, high volume pharmacogenomic oncology tests widely used in Ontario.

The Medical Advisory Secretariat, and its research collaborator, THETA, conducted a mega-analysis to address the effectiveness of these tests at predicting which patients will respond to a given therapy, and is their therapy cost-effective compared to alternative methods of care. A field evaluation of Oncotype-DX is being performed by the Ontario Clinical Oncology Group, expected to be completed by 2013.

As well as contextualizing the evidence for these tests, the expert panel convened was asked to identify emerging or existing pharmacogenomic tests that present a real pressure to the healthcare system. Through this exercise, the panel identified priorities for evidence-based analyses for the province. OHTAC has therefore recommended that provincial capacity be identified and secured as soon as possible for pharmagenomic testing with respect to these treatments: Warfarin, Carbamazepine, Abacavir, Azathioprine, HER-2/neu in gastric cancer, B-Raf mutations and inhibitors in melanoma, BRCA 1 and 2 in ovarian cancer, and ALK mutations and inhibitors in lung cancer and neuroblastoma. OHTAC also supported the recommendation that a mechanism be identified to determine which pharmacogenomic tests are emerging and to prioritize them for assessment.

ONTARIO HEALTH QUALITY COUNCIL
O/A HEALTH QUALITY ONTARIO

FINANCIAL STATEMENTS
MARCH 31, 2012

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The attached notes are an integral part of these financial statements.

LOFTUS ALLEN & CO. PROFESSIONAL CORPORATION
CHARTERED ACCOUNTANTS

INDEPENDENT AUDITORS' REPORT

To The Board of Ontario Health Quality Council o/a Health Quality Ontario:

We have audited the accompanying financial statements of Ontario Health Quality Council o/a Health Quality Ontario, which comprise the statement of financial position as at March 31, 2012, and the statements of operations, and cash flows for the year then ended, along with a summary of significant accounting policies, related schedules, and other explanatory information The financial statements have been prepared by management based on the financial reporting provisions established by the Ministry of Health and Long-Term Care and the Canadian Public sector accounting standards.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditors consider internal control relevant to the entity's preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

5409 Eglinton Ave. W., Suite 107, Toronto, ON M9C 5K6
Telephone & Fax: 905-566-7333 Toll Free: 1-866-749-9228
www.loftusallen.com

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CHARTERED ACCOUNTANTS

INDEPENDENT AUDITORS' REPORT *continued*

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Ontario Health Quality Council o/a Health Quality Ontario as at March 31, 2012, and the results of its operations and its cash flows for the year then ended in accordance with the Canadian public sector accounting standards. Without modifying our opinion, we draw attention to Note 3 of the financial statements which describes the basis of accounting. The financial statements are prepared to assist the Ontario Health Quality Council o/a Health Quality Ontario to meet the requirements of their funding agreement with the Ministry of Health and Long-Term Care. As a result, the financial statements may not be suitable for another purpose. Our report is intended solely for Ontario Health Quality Council o/a Health Quality Ontario and the Ministry of Health and Long-Term Care and should not be used by other parties.

Loftus Allen & Co
Professional Corporation

Chartered Accountants, authorized to practice
public accounting by The Institute of
Chartered Accountants of Ontario

Toronto, Ontario
June 22, 2012

5409 Eglinton Ave. W., Suite 107, Toronto, ON M9C 5K6
Telephone & Fax: 905-566-7333 Toll Free: 1-866-749-9228
www.loftusallen.com

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

STATEMENT OF FINANCIAL POSITION AS AT MARCH 31, 2012 (with comparative figures for 2011)

	2012	2011	April 1, 2011
FINANCIAL ASSETS			
Cash	$ 5,092,291	$ 232,661	$ 1,456,210
Cash for Severance, *Note 9*	86,668	-	-
Cash for Vacation credits, *Note 9*	11,070	-	-
Accounts receivable	-	441,000	-
	5,190,029	673,661	1,456,210
LIABILITIES			
Accounts payable and accrued liabilities	1,871,290	1,009,095	877,358
Severance funding liability, *Note 9*	86,668	-	-
Vacation credits liability, *Note 9*	11,070	-	-
Due to the Ministry of Health and Long Term Care, *Note 4*	3,303,284	9,953	625,850
	5,272,312	1,019,048	1,503,208
NET FINANCIAL ASSETS (DEBT)	(82,283)	(345,387)	(46,998)
NON-FINANCIAL ASSETS			
TANGIBLE CAPITAL ASSETS			
Computer and equipment	190,839	126,428	126,428
Office furniture and fixtures	903,823	80,313	80,313
Leasehold improvements	1,149,341	229,479	229,479
	2,244,003	436,220	436,220
Less: Accumulated amortization	2,244,003	436,220	436,220
	-	-	-
PREPAID EXPENSES	82,283	345,387	46,998
ACCUMULATED SURPLUS	$ -	$ -	$ -

APPROVED ON BEHALF OF THE BOARD:

Director

Director

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

STATEMENT OF OPERATIONS FOR THE YEAR ENDED MARCH 31, 2012 (with comparative figures for 2011)

	2012	2011
REVENUE		
Ministry of Health and Long Term Care	**$ 30,460,125**	$ 7,433,275
Speaking engagements	**8,439**	2,653
Interest	**55,876**	10,171
	30,524,440	7,446,099
EXPENSES		
Building the Organization – see schedule (page 32)	**5,335,725**	3,822,920
Research and Reporting – see schedule (page 32)	**1,833,980**	526,774
Evidence Based Advice – see schedule (page 33)	**2,442,381**	-
Quality Improvement expenses – see schedule (page 33)	**10,597,361**	3,086,452
Technology Fund – see schedule (page 34)	**4,602,120**	-
Transition Costs – see schedule (page 34)	**2,419,542**	-
	27,231,109	7,436,146
EXCESS OF REVENUE OVER EXPENSES	**3,293,331**	9,953
DUE TO THE MINISTRY OF HEALTH AND LONG TERM CARE, *Note 4*	**$ 3,293,331**	$ 9,953

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

SCHEDULE OF BUILDING THE ORGANIZATION: EXPENSES FOR THE YEAR ENDED MARCH 31, 2012
(with comparative figures for 2011)

	2012	2011
Salaries and benefits	$ 2,115,967	$ 2,397,674
Rent	833,665	518,754
Professional fees	634,371	118,002
Office equipment and leasehold improvements	326,892	81,776
IT Professional services	319,199	201,397
Telecommunications	221,031	71,533
Travel	160,182	57,177
Printing and photocopy	150,381	2,613
Graphic design and other costs	99,109	47,650
Education and training	74,466	-
Legal and audit services	82,380	96,642
Stationery and office supplies	62,477	25,592
Council honoraria	56,272	69,103
Finance and payroll costs	48,164	15,797
Courier and delivery	43,002	19,731
Events	35,017	-
Insurance	30,671	6,686
Web development	28,306	18,469
Publications and memberships	14,173	74,324
	$ 5,335,725	$ 3,822,920

SCHEDULE OF RESEARCH AND REPORTING EXPENSES FOR THE YEAR ENDED MARCH 31, 2012
(with comparative figures for 2011)

	2012	2011
Salaries and benefits	$ 1,219,801	$ 106,423
Professional fees	302,341	370,696
LTC Survey costs	200,000	-
Publications and literature	45,241	270
Events and travel	10,856	12,899
Translation and writing costs	28,890	36,486
Education and training	26,851	-
	$ 1,833,980	$ 526,774

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

SCHEDULE OF EVIDENCE-BASED ADVICE EXPENSES FOR THE YEAR ENDED MARCH 31, 2012
(with comparative figures for 2011)

	2012	2011
Salaries and benefits	$ 2,266,119	$ -
Field evaluations	125,000	-
Events and travel	32,525	-
Consulting research and communications	18,737	-
	$ 2,442,381	$ -

SCHEDULE OF QUALITY IMPROVEMENT EXPENSES FOR THE YEAR ENDED MARCH 31, 2012
(with comparative figures for 2011)

	2012	2011
Salaries and benefits	$ 8,635,894	$ 1,899,456
Events	688,112	430,556
Professional fees	443,434	413,787
Travel	353,038	83,178
Payments to other organizations	212,500	-
Education and training	120,237	115,076
Translation costs and writing costs	59,629	6,870
IT Professional services	34,229	-
Media and other expenses	26,466	116,518
Honoraria	23,822	21,011
	$ 10,597,361	$ 3,086,452

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

SCHEDULE OF TECHNOLOGY FUND FOR THE YEAR ENDED MARCH 31, 2012
(with comparative figures for 2011)

	2012	2011
PATH	$ 1,673,672	$ -
UHN	1,907,630	-
University of Toronto	576,400	-
McMaster University	444,418	-
	$ 4,602,120	$ -

SCHEDULE OF TRANSITION EXPENSES FOR THE YEAR ENDED MARCH 31, 2012
(with comparative figures for 2011)

	2012	2011
Office equipment and maintenance	$ 1,357,195	$ -
Professional fees	583,476	-
Lease	296,695	-
IT Professional services	154,996	-
Legal	27,180	-
	$ 2,419,542	$ -

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED MARCH 31, 2012 (with comparative figures for 2011)

	2012	2011
OPERATING TRANSACTIONS		
Cash received from:		
Ministry of Health and Long Term Care	$ 30,901,125	$ 6,992,275
Interest	55,876	10,171
Speaking engagements	8,439	2,653
	30,965,440	7,005,099
Cash paid for:		
Evidence based advice	(2,442,381)	-
Building the organization	(3,785,796)	(4,379,332)
Research and reporting	(1,833,980)	(744,063)
Quality improvement	(10,597,361)	(2,766,792)
Technology Fund	(4,602,120)	-
Special projects	-	(256,685)
Transition costs	(1,062,347)	-
	(24,323,985)	(8,146,872)
Cash provided by (applied to) operating activities	6,641,455	(1,141,773)
CAPITAL TRANSACTIONS		
Proceeds on sale of tangible capital assets	-	-
Cash used to acquire tangible capital assets	(1,684,087)	(81,776)
Cash provided by (applied to) capital transactions	(1,684,087)	(81,776)
INCREASE (DECREASE) IN CASH	4,957,368	(1,223,549)
CASH, beginning of year	232,661	1,456,210
CASH, end of year	$ 5,190,029	$ 232,661

The attached notes are an integral part of these financial statements.

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

NOTES TO THE FINANCIAL STATEMENTS MARCH 31, 2012

1. THE ORGANIZATION

The Ontario Health Quality Council (OHQC) is an independent agency, created under Ontario's *Commitment to the Future of Medicare Act* on September 12, 2005.

Under the *Excellent Care For All Act* (ECFAA) enacted June 3, 2010, OHQC's mandate was expanded to:

- Recommend and help health care providers adopt evidence based standards of care and best practices;
- Monitor and report on quality improvement efforts across health care sectors; and
- Lead provincial efforts to improve safety, quality, efficiency, and the patient experience across all health care sectors.

OHQC was granted the business name Health Quality Ontario (HQO) on February 15, 2011. On April 1, 2011, four organizations were merged into HQO. The four organizations are: the Medical Advisory Secretariat of the Ontario Ministry of Health and Long Term Care, the Centre for Healthcare Quality Improvement, Ontario Health Quality Council and the Quality Improvement and Innovation Partnership. In addition, HQO assumed responsibility for the Ontario Health Technology Advisory Committee and the Ontario Health Technology Evaluation Fund. HQO is proud to participate in the creation of the province's preeminent organization responsible for promoting and advancing quality within Ontario's healthcare system.

This merged organization coordinates, consolidates and strengthens the use of evidence based practice initiatives and technologies, supports continuous quality improvement and continues to monitor and publicly report on health system outcomes. HQO's mandate includes the recommendation of evidence informed care, providing continuous support for the adoption of standards of care among health care providers, and monitoring and reporting on Ontario's health system performance. The consolidation of the health quality infrastructure will increase accountability, build synergies amongst existing programs and allow the agency to focus on the patient's entire care journey across all sectors. HQO's goal is to support a more efficient, patient centered health care journey.

2. CONVERSION TO PUBLIC SECTOR ACCOUNTING STANDARDS

Commencing with the March 31, 2012 fiscal year, HQO adopted Canadian public sector accounting ("PSA") standards. These financial statements are the first financial statements in which HQO has applied Canadian public sector accounting standards.

There is no impact resulting from the conversion to Canadian public sector accounting standards in the accumulated surplus/deficit at the date on transition and the comparative annual surplus.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(a) Basis of accounting

These financial statements are prepared by management in accordance with Canadian public sector accounting standards for provincial reporting entities established by the Canadian Public sector accounting board except as noted in 3 (b).

(b) Tangible Capital assets

Tangible capital assets purchased with government funding are amortized 100% in the year of acquisition as long as the capital assets have been put to use. This policy is in accordance with the accounting policies outlined in the Ministry of Health and Long Term Care (MOHLTC) funding guidelines. MOHLTC funding is completely operational and not capital in nature.

(c) Prepaid expenses

Prepaid expenses include insurance and rent and are charged to expense over the periods expected to benefit from it.

(d) Donated materials and services

Value for donated materials and services by voluntary workers has not been recorded in the financial statements. These services are not normally purchased by the organization and their fair value is difficult to determine.

(e) Revenues and Expenses

The deferral method of accounting is used. Income is recognized as the funded expenditures are incurred. In accordance with the MOHLTC guidelines, certain items have been recognized as expenses although the deliverables have not all been received yet. These expenses are matched with the funding provided by the Ministry for this purpose.

(f) Measurement uncertainty

The preparation of financial statements in conformity with Canadian Public Sector Accounting Standards requires management to make estimates and assumptions that affect the reporting amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of the revenues and expenses during the period.

Estimates are based on the best information available at the time of preparation of the financial statements and are reviewed annually to reflect new information as it becomes available. Measurement uncertainty exists in these financial statements. Actual results could differ from these estimates.

4. DUE TO THE MINISTRY OF HEALTH AND LONG TERM CARE

In accordance with the Ministry of Health and Long Term Care (MOHLTC) financial policy, surplus funds received in the form of grants are recovered by the Ministry of Health subsequent to the year end in which the surplus occurred.

	2012	2011
Excess revenue over expenses in 2011	$ 9,953	$ 9,953
Excess revenue over expenses in 2012	3,293,331	-
Total repayable at year end	$ 3,303,284	$ 9,953

5. LEASE OBLIGATIONS

There were two property leases in place at the end of the fiscal year: the main location with a lease ending August 31, 2018, and a secondary location with a lease ending August 25, 2015. The net annual rent of the main lease is currently $218,746 until March 31, 2015 and will subsequently increase to $301,550 until August 31, 2018. The secondary lease was terminated on June 1, 2012 with a negotiated buyout. This buyout consisted of gross rent for seven months valued at $103,472 including HST. The annual net payments of the remaining rental premise during the next five years of the lease are estimated as follows:

2013	$218,746
2014	$218,746
2015	$218,746
2016	$301,550
2017	$301,550

ONTARIO HEALTH QUALITY COUNCIL O/A HEALTH QUALITY ONTARIO

6. ECONOMIC DEPENDENCE

The OHQC receives all of its funding from the MOHLTC.

7. FINANCIAL INSTRUMENTS

Fair value. The carrying value of cash, accounts payable and accrued liabilities as reflected in the financial position approximate their respective fair values due to their short term maturity or capacity for prompt liquidation. The organization holds all of its cash at one financial institution.

8. SUBSEQUENT EVENTS

As mentioned in Note 5, one of the property leases ended on June 1, 2012 with a buyout of $103,472.

9. COMMITMENTS

Severance and vacation credits earned by employees from MOHLTC were transferred to the organization on April 1, 2011 when the merger of the different organizations occurred.

10. COMPARATIVE FIGURES

Certain comparative figures have been reclassified to comply with presentation adopted in the current year.

SCHEDULE OF REVENUE, EXPENSES AND BUDGET FOR THE YEAR ENDED MARCH 31, 2012

	ACTUAL	BUDGET
REVENUE		
Ministry of Health and Long Term Care	$ 30,460,125	$ 30,460,125
Speaking engagements	8,439	-
Interest	55,876	-
	30,524,440	30,460,125
EXPENSES		
Building the Organization	5,335,725	3,673,656
Research and Reporting	1,833,980	3,057,800
Evidence Based Advice	2,442,381	3,153,247
Quality Improvement expenses	10,597,361	13,555,922
Technology Fund	4,602,120	4,600,000
Transition Costs	2,419,542	2,419,500
	27,231,109	30,460,125
DUE TO THE MINISTRY OF HEALTH AND LONG TERM CARE	$ 3,293,331	$ -

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Health Quality Ontario
130 Bloor Street West, 10th Floor
Toronto, ON M5S 1N5
Tel: 416-323-6868 | 1-866-623-6868
Fax: 416-323-9261

www.hqontario.ca